

Letters to the Editor

DR. GARCIA REPORTS AN EYEWITNESS ACCOUNT OF FREUD AND WAGNER-JAUREGG

Sir:

An unexpected stroke of good fortune allowed me to make the acquaintance of someone who could provide firsthand information on Julius Wagner-Jauregg and Sigmund Freud—the two principals of K. R. Eissler's *Freud as an Expert Witness* (1), which I recently reviewed for the *Journal* (2).

My informant, a 92-year-old Jewish woman of great charm, culture and perspicacity, had studied medicine at the University of Vienna sometime between 1916 and 1918. She could not recall the exact year of attendance there, but knowledge of Freud's activities at the University make 1916–17 most probable—see Gay, pp. 368–9 (3). Her comments add a touch of color to our pictures of the Nobel laureate and the founder of psychoanalysis.

Dr. O.* reported that Freud was rather famous among the University medical students. Out of curiosity she attended several of his lectures, presumably those that eventually became the *Introductory Lectures on Psycho-Analysis* (4). Freud did not cut an especially impressive physical figure: he was short and spoke in a relatively high-pitched voice. However, his manner of presentation and the compelling contents of his lectures inspired admiration. Dr. O. had no doubt that Freud was a great scientist: she was deeply impressed by the persuasive logic, the scientific stamp of Freud's arguments and contrasted them with the relatively haphazard approach of general psychiatry (as she understood it). She also noted that it had been common knowledge among the students that Viennese anti-semitism had prevented Freud's professional advancement at the University.

In contrast, Dr. O. described Professor Julius Wagner-Jauregg, future recipient of the Nobel prize for his malaria cure of neurosyphilis, as a man of great charisma, physically formidable. She recalled specifically having witnessed his interview of an apparently psychotic patient. When Wagner-Jauregg asked the patient what he reminded him of, the patient likened the professor to a wild beast. Upon hearing this, the eminent professor threw his head back and laughed deeply and heartily—in a way which Dr. O. thought was quite eccentric. She jokingly asserted that Wagner-Jauregg seemed as mad as his patient.

Dr. O.'s memories of these influential personalities went no further. Sadly, she was claimed by the ravages of old age and its attendant physical ailments before I could obtain an audiotape of her account for the Sigmund Freud Archives, to which she was most eager to contribute.

It is noteworthy that Dr. O.'s comments reveal her to have been at odds with the prevailing opinions of the intellectual establishment. Psychoanalysis was held in low esteem by academic psychiatry, whose foremost Viennese representative was none other than Wagner-Jauregg (5). However, as befits youth, the crusty preconceptions of the old order can more easily be surrendered in the face of compelling challenges: the bright and

*for reasons beyond the scope of discussion, confidentiality is necessary.

inquisitive medical student was well-disposed towards Freud's revolutionary work, the appreciation of which can find no more eloquent manifestation than the acknowledgment of its fundamentally scientific nature.

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5. Eissler KR: op cit, p 21

DR. TULLY INTRODUCES A NEW JOURNAL OF INTEREST TO RESIDENTS

Sir:

I extend an invitation to my fellow residents to read the new American Journal of Preventive Psychiatry and Neurology. The mission of the Journal is to encourage physicians with an interest or special expertise in Psychiatry, Neurology, or Preventive Medicine to develop a better understanding of the preventive and treatment aspects of neuropsychiatric disease. Our flagship issue in January 1988 was devoted to AIDS.

The Journal is supported by a grant from the Metropolitan Clinics of Counseling. Please address all correspondence to the Editor in Chief of Psychiatry, Stephen N. Barton, M.D., Ph.D., Metropolitan Clinics of Counseling, Suite 325 N, 2550 University Ave. East, St. Paul, Minnesota 55114. The Editors urge residents to submit research articles; we are listening for new voices.

Elizabeth M. Tully, M.D., M.S.
Deputy Editor

DR. SLAP COMMENTS ON "SUPERVISING RESIDENTS TREATING MULTIPROBLEM PATIENTS: TRANSFORMATIONS OF THERAPEUTIC NARCISSISM"

Sir:

Drs. Olson, Westhead and Goodwin's article, "Supervising Residents Treating Multiproblem Patients: Transformations of Therapeutic Narcissism" (1) deals with the potential for narcissistic injury to residents (and one might extend this to non-medical trainees) who treat severely disturbed patients while being supervised. The authors turn to Kohut (1966), asserting that his ideas on the healthy transformations of narcissism provide a useful language and framework for considering this issue. Kohut

listed five such transformations: creativity, empathy, acknowledgment of finiteness, humor, and wisdom; the authors attempt to illustrate the manifestations of these derivatives of narcissism in the supervisions they describe.

These efforts seem to me forced and tendentious. For example, the illustration for creativity was the referral the resident made of a patient to a shelter for battered women. The referral was made in response to a crisis and was considered in supervision after the fact. To use this as an instance of creativity stretches the meaning of that concept well beyond what Kohut describes. Similarly, Kohut wrote of the acknowledgment of the finiteness of one's existence whereas the illustration in the paper relates to the acknowledgment of the limits of one's ability or, since the resident was dealing with the possibility of her patient's suicide, acknowledgment of the finiteness of the patient's life. In either case, it was not what Kohut was writing about.

It seems to me too that the authors are inconsistent in that they suggest that residents rightly complain about supervision "degenerating into therapy" and yet the main point of the article is that an important agenda of supervision is "making the often drained and narcissistically injured therapist feel better." Further, they appear to give little importance to the therapist's understanding of the dynamics. At least this is not mentioned at all in the statement of the problem unless there is an allusion to dynamic understanding in the passing mention of process in the first paragraph. Obviously, the therapist who has a grasp of what is going on in the patient will have a sense of the magnitude of the pathology and will be able to think in terms of a therapeutic strategy. Without this, the beginning therapist is more likely to focus on his or her sense of impotence.

Yet in spite of these questions about the authors' theoretical inferences and formulations, I have a sense, derived from the clinical and supervisory anecdotes, that they are skilled and insightful therapists and tactful and sensitive supervisors. I am reasonably confident that if we were to put aside abstract theory and to conduct a dialogue on a clinical level, our differences would tend to vanish.

I am not an adherent of Kohut and would not formulate my ideas of how a supervisor should function in terms of self psychology. The best formulation I have seen is Jacob's (1981) concept of the "supervisory pact." (2) He was writing of psychoanalytic supervision; yet his ideas apply as well to the supervision of psychotherapy. In this pact the supervisor promises to respect the therapist's autonomy as far as possible both in the conduct of the therapy and in regard to the therapist's personal equation. Observations about the therapist's personal issues will be minimal, only in the service of the work, and limited to observing phenomena directly pertinent to the work; these observations will not be a "wild analysis" of the genetics of the therapist's presumed problems. He goes on:

Let us both consider that we are on the frontier of therapeutic knowledge; we are both students. It is granted that I have had more experience, but an overemphasis on the student-teacher relationship will detract from a mutual exploratory attitude toward this unique "experiment in nature": your case.

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DR. DASGUPTA COMMENTS ON "THE USE OF MAINTENANCE
ELECTROCONVULSIVE THERAPY FOR RELAPSING DEPRESSION"

Sir:

I was very interested in the article "The Use of Maintenance Electroconvulsive Therapy for Relapsing Depression" by Ted Matzen, Ronald Martin, Tim Watt and Douglas Reilly (1).

Recurrent affective disorders are highly prevalent and can produce devastating consequences for patients and their families. Between 50% and 85% of patients with a major depressive episode at university medical centers will have at least one subsequent depressive episode during their lifetime. The NIMH/NIH Consensus Development Conference Statement recommends the use of lithium carbonate or tricyclic antidepressants in the prevention of recurrences of depressive episodes (2). In certain patients, lithium carbonate and tricyclic antidepressants fail to prevent recurrent affective episodes. The Consensus Statement did not address maintenance electroconvulsive therapy (ECT) as an alternative prophylactic treatment.

Maintenance electroconvulsive therapy (ECT) has been used since the 1940's for prophylaxis of depression, mania and schizophrenia. Several authors have reported longer symptom-free periods in patients receiving maintenance ECT compared with those receiving psychotherapy or no treatment (3,4). Since the introduction of antipsychotics, antidepressants and lithium carbonate, the use of maintenance ECT has decreased, and no controlled studies comparing efficacy of psychotropics and maintenance ECT have been performed.

Matzen et al. outline several cases, most of which report longer symptom-free intervals with maintenance ECT versus antidepressant or lithium carbonate continuation or maintenance treatment. The authors summarize their case examples by comparing 30 hospitalizations for depression occurring during the two years prior to ECT with 10 hospitalizations during the two year post-maintenance ECT period. Since the cases differ greatly with respect to frequency and duration of maintenance treatment and previous medications, it is difficult to draw firm conclusions. However, the decreased frequency of hospitalizations in this patient group is encouraging and suggests a beneficial effect from maintenance ECT.

Maintenance ECT is used at the University of Wisconsin for patients with unipolar or bipolar depression who have relapsed despite vigorous pharmacological continuation and maintenance treatment. We administer maintenance ECT using the same guidelines for frequency and duration as the authors, and often prescribe concurrent antidepressants. We are reluctant to prescribe concurrent lithium carbonate because of case reports

suggesting delirium induced by this combination. If patients, family members or psychiatrists note re-emergence of depressive symptoms, we increase the frequency of treatments to weekly or biweekly for one to two months and later attempt to taper as symptoms allow. Although we have not systemically reviewed our cases, I suspect our results would be similar to the authors'.

Clearly, many patients with unipolar or bipolar depression relapse despite proper pharmacologic treatment. Complications of recurrent depressive episodes include marked impairment in social and occupational functioning, increased deaths from non-psychiatric causes and accidents, and a 30-fold increase in suicide risk. The case reports and reviews cited above suggest maintenance ECT may be effective in preventing relapse or recurrence of depression. Given our present knowledge, selection criteria and guidelines for practice outlined in the article are appropriate. However, controlled studies comparing maintenance ECT with pharmacologic interventions, as well as studies addressing frequency and duration of maintenance ECT are crucial. I believe maintenance ECT represents an important alternative in the treatment of recurrent depression and hope it will be more thoroughly studied in the not-too-distant future.

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